

STATEMENT

On Reforming Medicare's Physician Payment System

Bruce C. Vladeck
Executive Director and Senior Health Policy Advisor
Health Sciences Advisory Services
Ernst & Young, LLP

5 Times Square
New York, NY 10036
(212) 773-0111

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Mr. Chairman, Mr. Camp, Members of the Subcommittee, my name is Bruce C. Vladeck, and it is my great honor and privilege to have the opportunity to appear before you again today. I am currently Executive Director and Senior Health Policy Advisor in the Health Sciences Advisory Services of Ernst & Young, but I hasten to add that the views I will be expressing today are solely my own, and should not be taken for the opinions of Ernst & Young, or any of its affiliates or clients. Instead, I'm speaking today on the basis of my experience with the Medicare Physician Payment System during my four and a half years as Administrator of the Health Care Financing Administration, and my career-long involvement with the issues of providing primary care services, especially to residents of underserved areas.

I think we can all agree that the Medicare Physician Payment System, in its current form, is profoundly broken. The annual drama associated with the irrationality of the Sustained Growth Rate (SGR) system serves no one's interests very well. As has been frequently noted by this Subcommittee, as well as other authoritative bodies, preoccupation with fixing the effects of the SGR also diverts time and attention from other important dimensions of the physician payment issue, most notably the continuing reallocation of funds from primary care services to specialty procedures, precisely in the wrong direction. This reallocation, in turn, arises from a number of specific problems in the operation of the system, which have been widely discussed and in many instances previously addressed by the Subcommittee.

In my brief remarks this morning, I will quickly summarize some of the major problems with the current system. I will then offer some general observations about the

nature of payment systems, the operations of the Medicare program, and the difficulties faced by the Congress in seeking to legislate improvements in those systems. On the basis of those propositions, I will then offer my own suggestions for your consideration as ways to address these issues in the relatively near future. I note that many of those suggestions have already been made, or acted on, by this Subcommittee, MedPAC, the GAO, or other authoritative sources.

Problems With the Current System

The Medicare Physician Payment system was originally designed to shift payments from specialists and interventional procedures to primary care services, and thereby to help redress the imbalance in the American health care system between primary and specialty care; to provide greater control of program costs without impairing beneficiary access; and to provide a more rational, scientifically-based method for establishing the relative prices of different services provided by physicians. It is now meeting none of those goals satisfactorily.

In its first several years of operation in the early '90s, the Medicare payment system did indeed shift substantial resources from specialty to primary care, but since then the direction has been reversed, as a result of the process by which the Resource-Based Relative Value Scale (RBRVS) is revised and updated, the operations of the SGR formula, which ironically rewards fast-growing services while discouraging those that grow more slowly, and of changes in the physician marketplace. This is not just an abstract problem. Instead, there is widespread agreement that the current imbalance between primary and specialty services in the American health care system increases

costs and, perhaps more importantly, impairs the ability to improve the quality of care, particularly for individuals with significant chronic illnesses – an especially important issue for Medicare, since Medicare beneficiaries are far more likely to experience such illnesses.

It has long been well-established that most of the countries that outperform the United States in health care quality and costs have higher ratios of primary care to total physicians than we do; more recent research by the group at Dartmouth has shown a similar pattern across American counties. The explanation offered for this phenomenon is that an appropriate balance between primary care and specialty physicians leads to more effective management of the care of chronically-ill patients, and more judicious use of specialty-provided procedures.

Yet over the last decade, the proportion of American medical graduates pursuing primary care careers has fallen alarmingly, in part because medical students and residents are sensitive to the income implications of specialty choices, in part because they see the growing frustration and discontent of active primary care practitioners. The impact of Medicare's payment system on this phenomenon is not limited, moreover, to Medicare payments in themselves; most private insurers use the RBRVS methodology, despite all its flaws, as the basis for determining relative physician fees, even if they use different conversion factors. In recent years, some private insurers, frustrated by the effects of RBRVS on the availability and quality of primary care services, have experimented with alternative payment methods for primary care services, but those experiments are not yet sufficiently developed or widespread to have had much of an effect on the overall organization of care.

It's important to understand that the disincentives for primary care extend beyond the relative weights in the RBRVS system. Analysis of the problems in primary care, especially for the management of chronic illness, increasingly focus on the need for infrastructure investment – in information technology, staff capabilities, and care management support – in primary care practices. The increasing migration of diagnostic and treatment technologies, including imaging, laboratory, and infusion services, to specialty physician offices makes available to them the technical component payment as a vehicle for financing investments; no such parallel exists in primary care practices.

The Medicare physician payment system has also not been especially successful at controlling costs. The SGR process produces unacceptably low updates in the conversion factor, which the Congress regularly feels obligated to override, but because the entire process runs through the conversion factor, the ironic result is to suppress payments for slower-growing services, such as Evaluation and Management, while maintaining the incentives to increase the volume of those services that are increasing more quickly, such as diagnostic radiology. At the same time, the process of updating the RBRVS has a probably unavoidable upward bias, so the well-established codes, like most of those for primary care, continuously fall relatively further behind.

Some General Considerations on Medicare Payment

When I last appeared before this Subcommittee approximately eighteen months ago on a similar subject, I offered a number of general observations about Medicare payment policy which I thought might inform thinking about possible changes to

physician payment policy. I think they still apply, but in the interests of brevity and completeness, I've updated them modestly:

- You can only do so many things at once. If we can change the Physician Payment System to get the right balance between primary and specialty care, maintain beneficiary access, and have reasonable cost containment, that would be enough of an accomplishment in itself. We also need to improve quality and better align incentives between physicians and other providers, but there are other mechanisms for pursuing those goals.
- It's important not to overestimate the ability of policymakers to fine-tune incentives to achieve the desired goals. A little more humility in this regard would serve us all well. The Medicare physician payment system itself perhaps serves as the best cautionary example of good intentions gone awry. Health care is very complicated, and the behaviors of health care providers are affected by many things; providers may "follow the money," but they follow other imperatives as well, such as public and peer pressure and their own aspirations to professional excellence.
- In the same vein, it's important not to overestimate how "scientific" the rate-setting process is, or can ever be. The Practice Expense component of the Medicare Fee Schedule has roughly as much weight as Work Effort, yet anyone who has lived through the fights over relative Practice Expenses knows how little real data underlies current policies. Similarly, the Committee responsible for updating the RBRVS is comprised of real experts, but it's still a committee.

- Finally, all these considerations point to the need to view payment policymaking as a continuous, iterative process, one that will necessarily – and perhaps desirably – be characterized by constant refinement, modification, and experimentation.

Specific Suggestions

In this context, I offer my own recommendations for short-term steps the Congress could take to begin to alleviate some of the current problems in the Medicare Physician Payment System. As I noted above, many of these specific suggestions are based directly on recommendations by others, including previous actions taken by this Subcommittee.

1. First, in the short run, the Congress should immediately increase the weights of Evaluation and Management codes by some necessarily arbitrary amount, as a pure policy adjustment. If these increases are “budget neutral,” and the conclusions of most policy analysts who have studied Medicare Physician Payment are correct, doing so will actually save some money, since the budget neutrality adjustment will reduce the relative prices of procedural services, and thus the size of the incentives for physicians to increase the volume of them.
2. At the same time, the Congress should adopt a form of MedPAC’s recommendation for a primary care “add-on” to increase the fees of physicians who are really providing primary care, as defined by the proportion of Evaluation and Management services in their total billings. Given my earlier comments

about the need for infrastructure to support effective primary care practices, this add-on should be constructed as part of the practice expense component, again on a budget-neutral basis. This adjustment would parallel the expanded Medical Home Demonstration project called for in MIPPA last year, but I think we should move forward without waiting for the results of that demonstration; the size and specifics of the adjustment can be further modified once demonstration results are available.

3. As it did last year in the House version of the CHAMP Act, the Congress should modify the SGR to provide for separate updates for as many as six categories of physician services; exclude drugs, laboratory, and other “incident to” services from the calculation; and provide a “glide path” for meeting budgetary targets over a period of years. Any remaining savings required by budgetary imperatives should be achieved by savings in other Part B expenditures, especially laboratory and DMEPOS.
4. In the view of many analysts, the problems with the RBRVS, particularly its treatment of primary care services, will never be completely resolved so long as the existing definitions and codes for Evaluation and Management services remain in place. In addition to all the other work now being done on physician payment, I would urge the Congress to request that MedPAC and the GAO give immediate attention to the evaluation and – if necessary – development of alternative coding systems for physician services, especially including primary care services.

I know that many others will argue that a more radical approach is needed, that we should scrap the fee-for-service system, with its inherent incentives for increased utilization and its lack of explicit support for care coordination, altogether, in favor of some other payment methods. I would note only two points in response. First, most of the other nations that provide high-quality medical care to their citizens at lower cost than we do, in part by relying more heavily on primary care services, continue to employ some variant of fee-for-service in their methods for most physician payments, although some use additional or separate mechanisms specifically for primary care. Second, despite the obvious theoretical advantages of capitation-based payment methods, most private insurers in the United States, including most HMOs, have increasingly moved away from capitation methods in their private business. They've learned, at a minimum, that capitation-based systems have their own limitations and shortcomings, especially in an environment in which most of the physician community is still organized around relatively small, single-specialty practices.

Over time, in my view, we will never develop adequately satisfactory alternatives to our current payment methods until a far larger proportion of American physicians are organized in multi-specialty group practices, whether free-standing or hospital-based. We now have two generations of data confirming that such practices outperform other models of physician organization in cost, quality, and care coordination. Despite the current Medicare Demonstration experiments in this area, I am skeptical that modification of payment systems will significantly accelerate movement in this direction, but I would also urge the Congress to explore other methods it might encourage in this regard.

Again, it has been a privilege and a pleasure to have the opportunity to share these views with you, and I'd be happy to respond to any questions you might have.

Thank you very much.